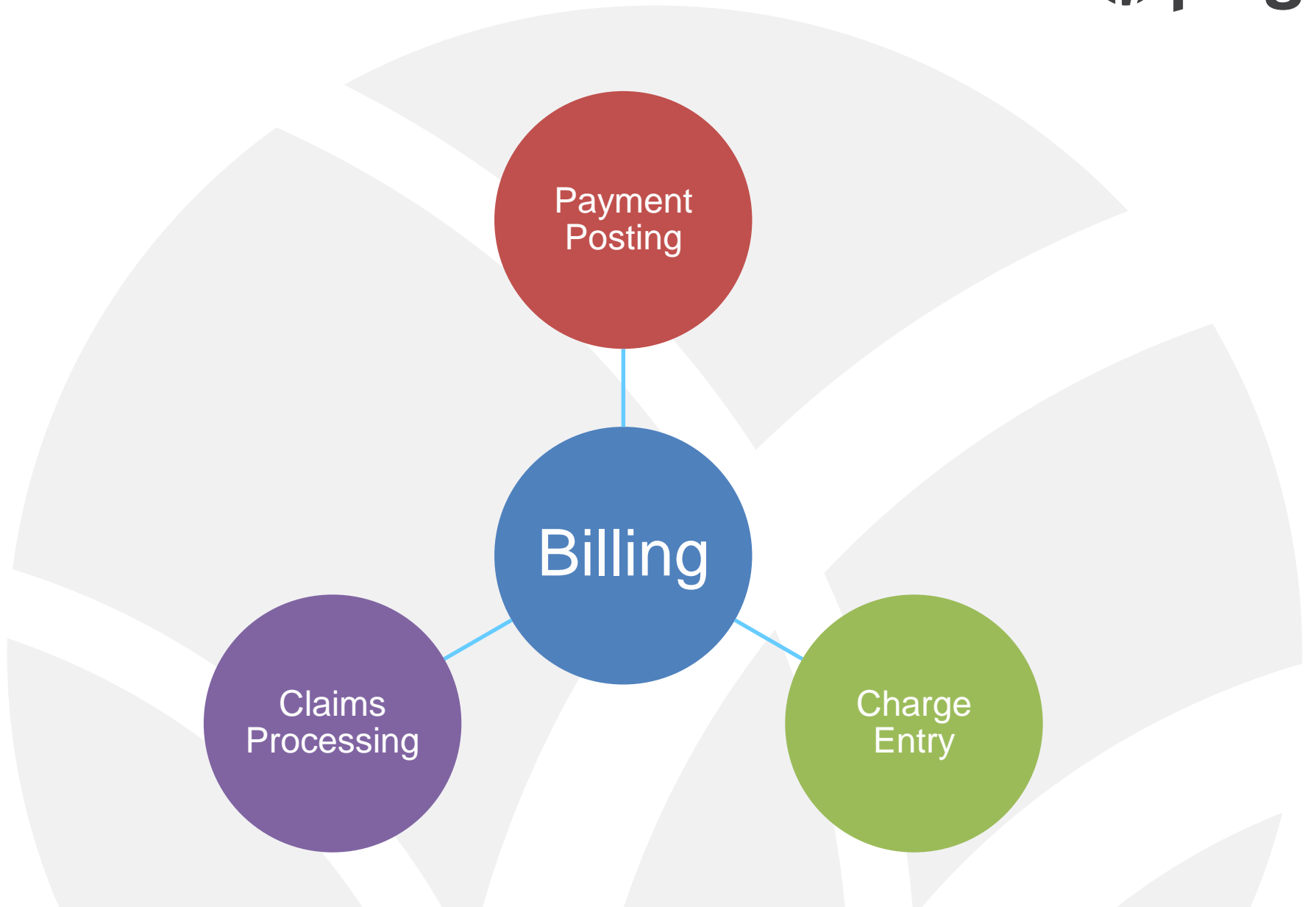# ATTRIBUTES OF A BETTER PERFORMING BILLING DEPARTMENT

pmg

REVENUE CYCLE . CHC EXPERTISE
PEACE OF MIND

Agenda

- Introduction

- Processes for the Revenue Cycle

- Front Desk

- Documentation & Coding

- Charge Entry

- Claims Processing

- Payment Posting

- Denial Management

- AR Management

- Key Performance Indicators (KPI)
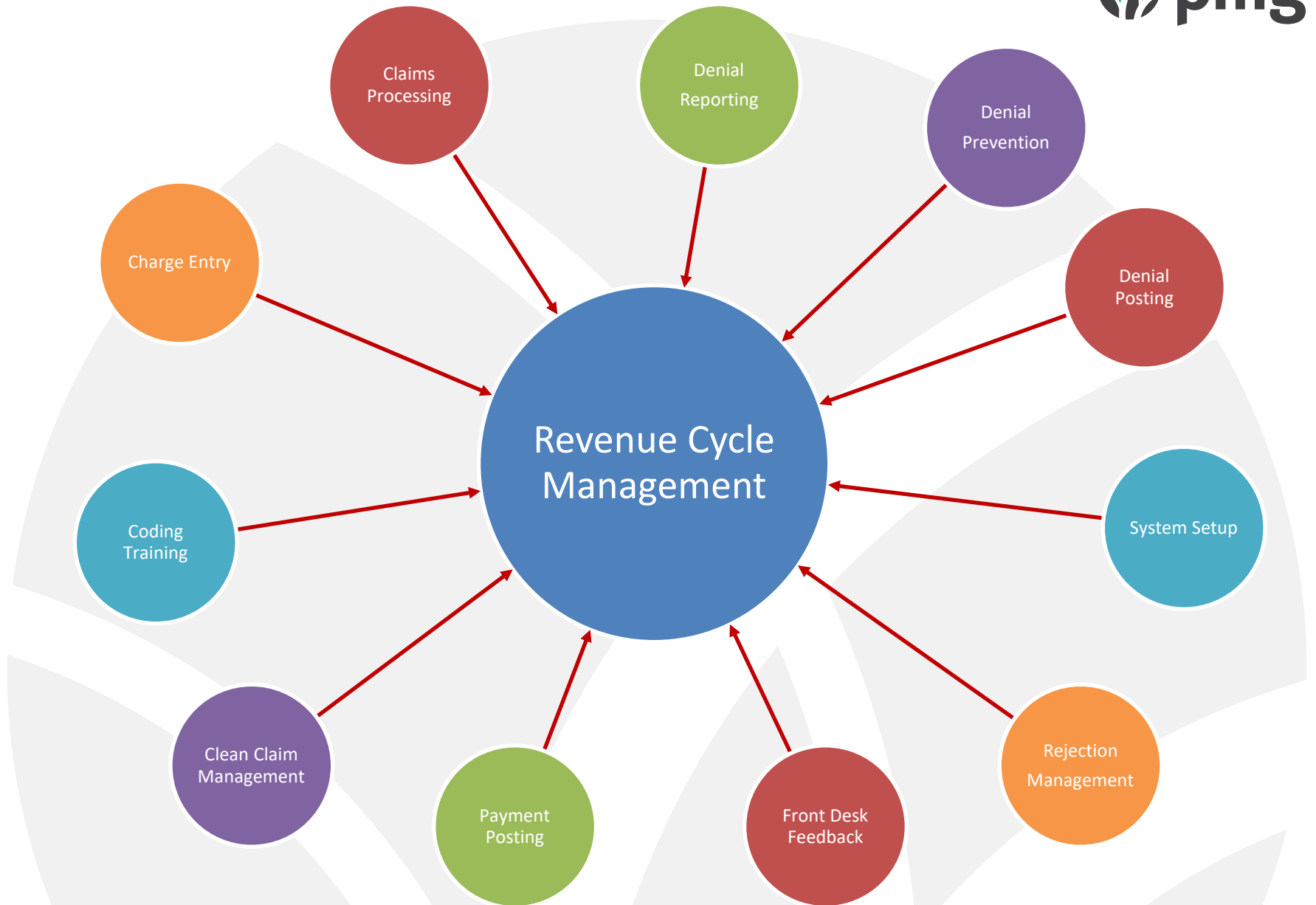
- Questions & Final Thoughts

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Revenue Cycle Management

Claims Processing

Denial Reporting

Denial Prevention

Charge Entry

Denial Posting

Coding Training

System Setup

Clean Claim Management

Payment Posting

Front Desk Feedback

Rejection Management

Auditing…The By-products

- Structure

- Documented processes

- Clear roles & responsibilities

- Regulatory compliance

- Optimized reimbursement

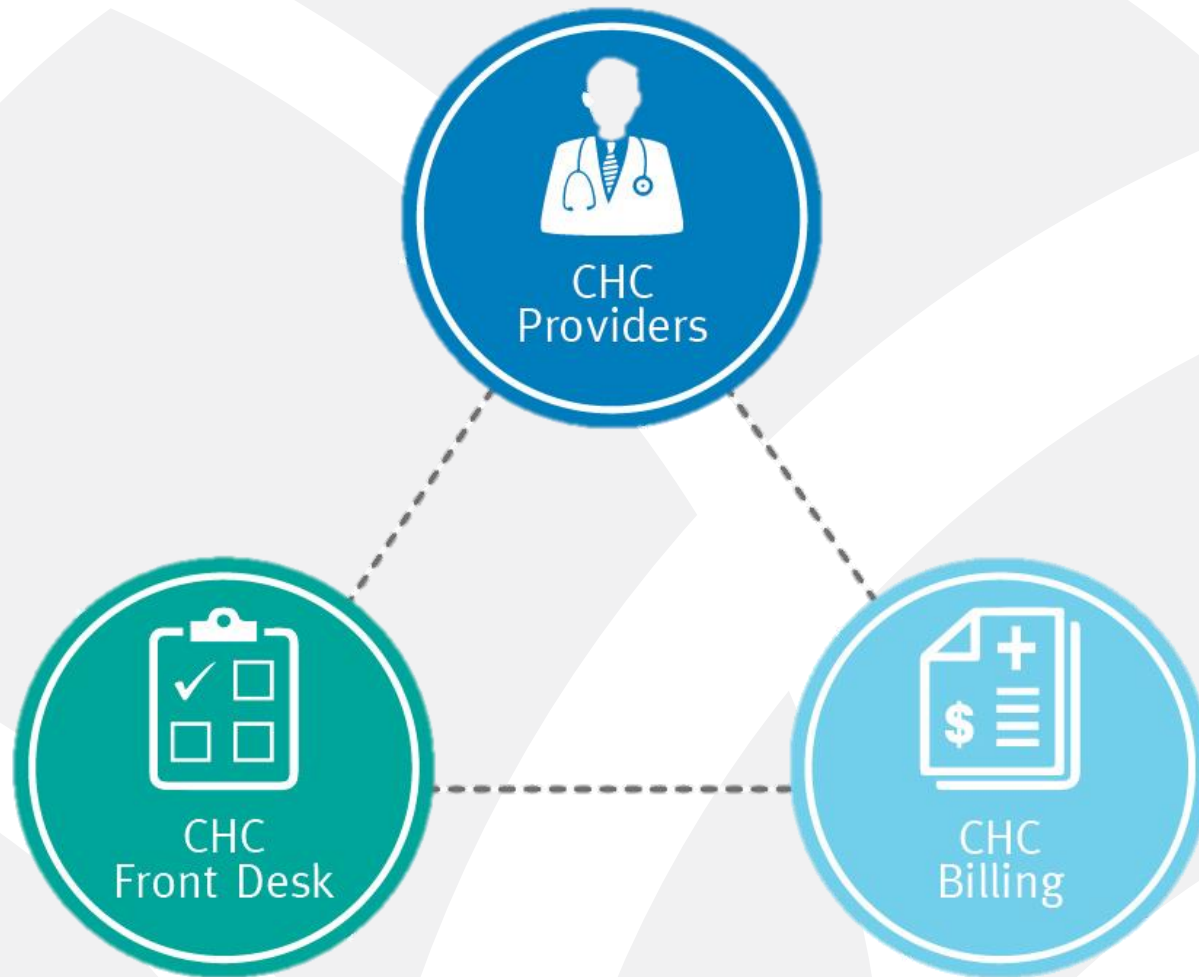- Process improvement - efficiencies

Where To Start And Who Is Involved?

- Start at the beginning!

- Involve stakeholders

- Make a plan

  – By payer (RCM/front desk)

  – By department

  – By site

  – By role

- Get buy-in

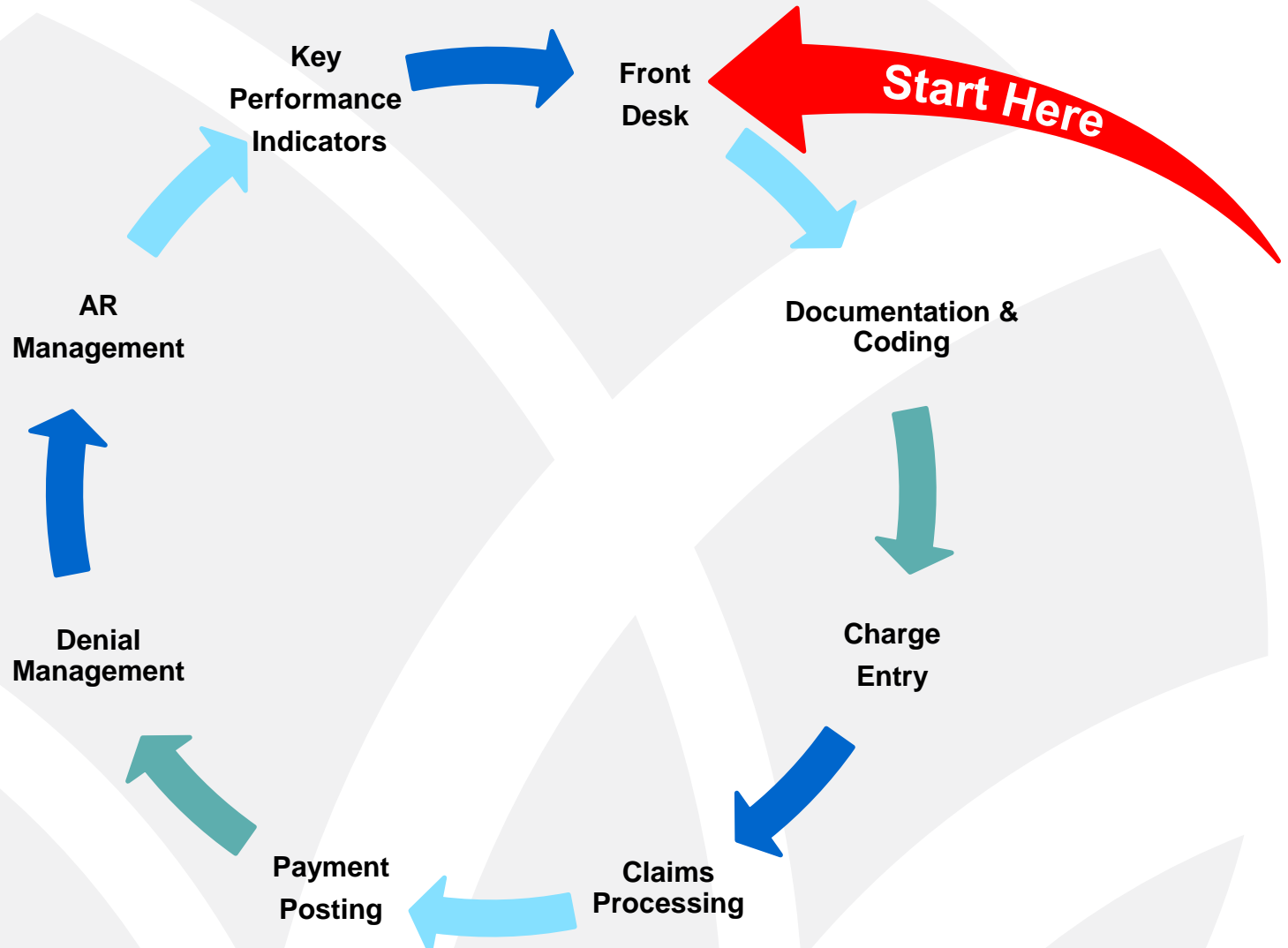- Stay focused

- Be patient

CHC Mantra

Get paid as much as possible (legally and ethically) as often as able so you can afford to give it away when you want.
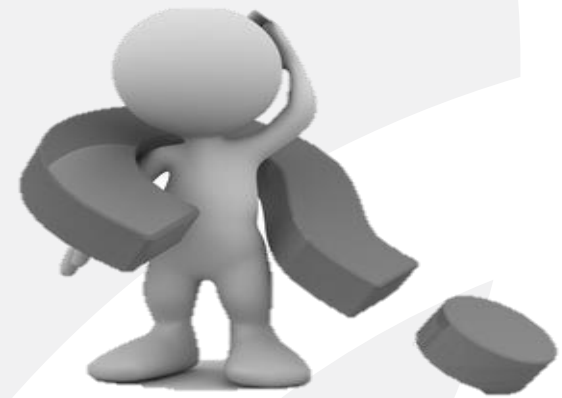
Who Owns The Revenue Cycle?

Processes & Audits
For The Revenue Cycle

Key Performance Indicators

Front Desk

Start Here

AR Management

Documentation & Coding

Denial Management

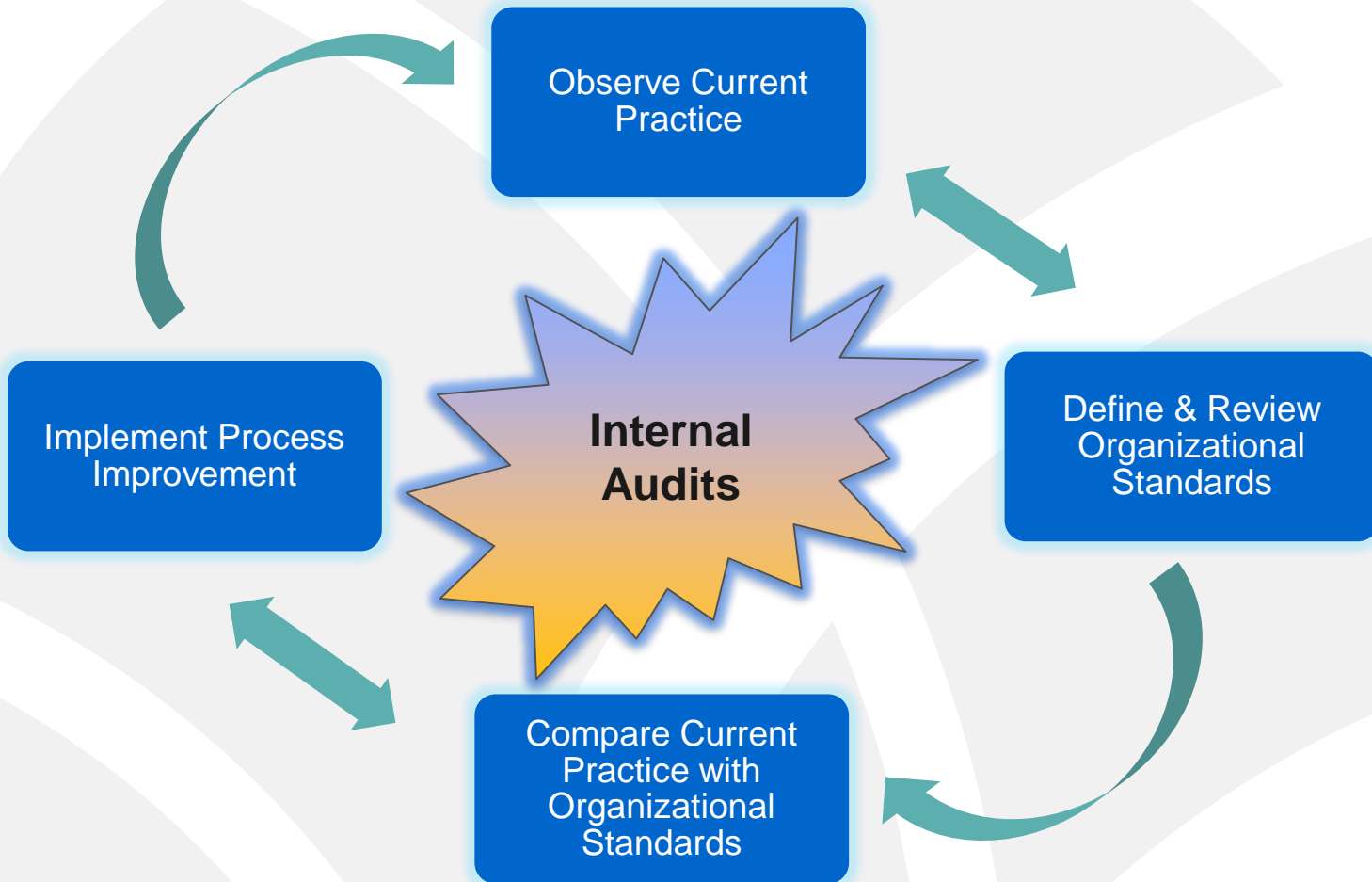**Charge Entry**

Payment Posting

Claims Processing

Auditing… What Is The Goal?

- Define success?

- Two equally important goals

#1 Get paid what we deserve

    – No more & no less

#2 Comply with laws, regulations and policies

Conducting Internal Audits

Internal Audits

- Observe Current Practice
- Define & Review Organizational Standards
- Compare Current Practice with Organizational Standards
- Implement Process Improvement

Processes & Audits
For The Revenue Cycle

Front Desk

Where It All Begins… Front Desk

"Why'd they send you here when we are the busiest?"

- Consistent check-in & check-out process
- Eligibility & interpretation
  - Medical, Dental, Behavioral Health, WC
- Know financial programs available
- Know payer requirements
  - Copay vs. coinsurance vs. deductible
- Requisite UDS data capture
- Permitted income documentation
- SFDS mastery
- Prior-auth or referral process

Front Desk… Elevated Engagement

- Remember: entry level yet difficult mastery
  - Public relations/image
  - $ capture
  - PM
  - COB/Payer policies
  - Acceptable SFDS documentation
- Benchmarks
  - Average $ per patient visit
  - Eligibility/demographic accuracy
  - SFDS on ALL patients
- What do with top performers?
  - Promote… sometimes to failure
  - Broadband… top tier teaches newbies

# Processes And Audits
For The Revenue Cycle

Front Desk

Documentation & Coding

Medical Record Audit

"What do they do at that other front desk?"

- <u>Not</u> a clinical review

- Not shadowing so not all-out chart review

- This is about optimal revenue capture

- CPT & ICD accuracy

  – Documented services coded?

  – Coded to appropriate level?

  – Vaccines, procedures, & diagnostics?

- Lost visits: PMG experience

  – Seen but not billed

Medical Record Audit

Compliance = constant & appropriate translation

Service Rendered → **Service Documented**

↓

Service Coded

Service Billed ←

↓

Service Reimbursed
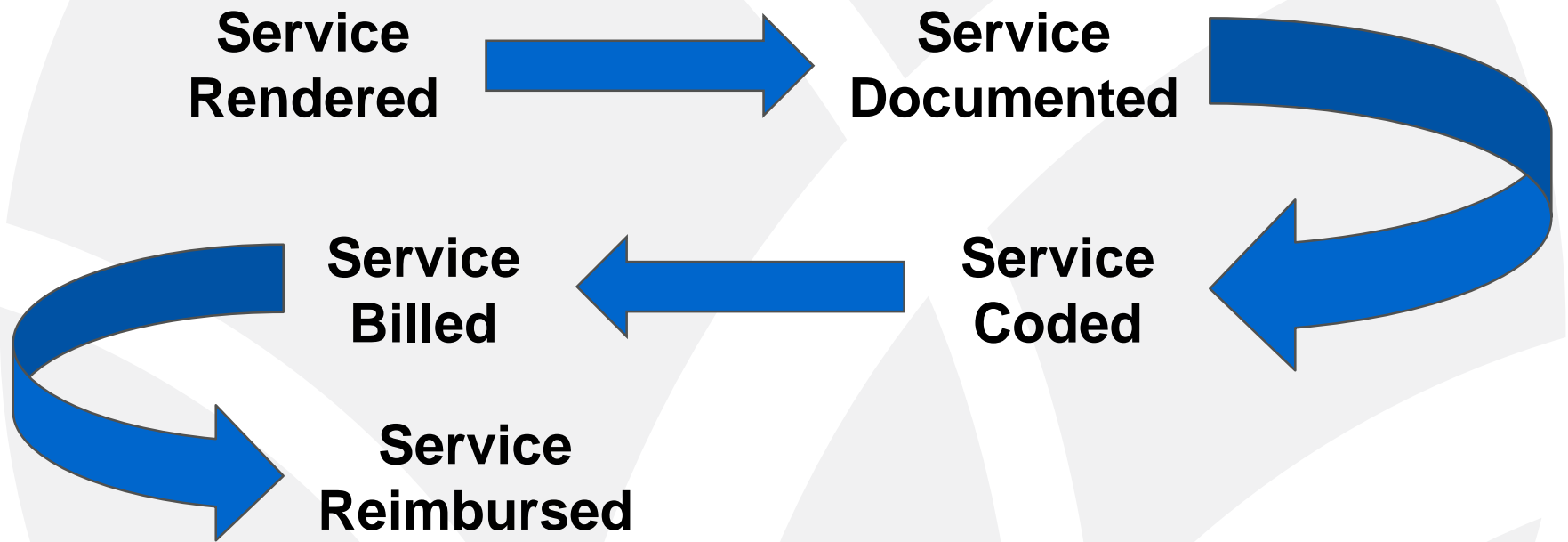
ANNUAL Coding Audit

Assure OIG Compliance Guidance:

- Determine chart selection schedule (may be staggered)
- Determine chart selection method (random or focused)
- Determine sample size (e.g., 10 charts/provider)
- Establish desired benchmarks
- Create improvement plan, as needed
- Track individual provider progress
- Identify problem providers
- Provide ongoing education
- Respond in writing as an internal document
- Share results internally, all impacted staff

Processes and Audits for the Revenue Cycle

Front Desk

Documentation & Coding

Charge Entry

Auditing Charge Entry

What does a charge entry audit encompass?

- Timeliness

- Quality

- Quantity

Charge Entry

PMG: "What is the lag for providers to 'close' charges?"

Client: "Doc retention is hard. We don't want to pressure them."

Timeliness

Result of delayed provider capture

- Aged AR before claim is sent (RCM takes heat)
- Lost services due to poor provider memory
- Compliance inquiries due to coding errors
- Inability to calculate charges at visit (TOS $ impact?)
- Providers running RCM/finance process

Auditing Charge Entry

Timeliness

- Lag time evaluation

- Start with your current process

  - Actual vs. benchmark: DOS to claim creation?

  - Reasonable?

  - Benchmark met?

  - Procedure creation/revision

    - Sign off by leadership: Finance, Ops, & Clinical

  - Reports to measure lag?

    - DOS to date of signature

    - DOS to date of entry

    - DOS to date of payment posting

Auditing Charge Entry

Client 1: Billed global ultrasound for 18 months, no equipment.

Client 2: Medicare PPS carve out… all non E&M services

Quality

- CHC billing/coding is VERY complicated
- 837-P, 837-I, 837-D… multiple formats & rules
- ALL parties have liability… providers to billers
- Certified coders?
- Certified coders who understand CHC nuances?
- QA process?
- Who audits the auditors/coders/billers?

Auditing Charge Entry

Quality

- Provider assigned codes correctly captured
    - Crosswalks (e.g., PPS "G" code or T1015)
- Coding modified?
    - By whom & following written procedure?
- RCM/Billing/Coding rules
    - Author?
    - Annually updated?
    - Oversight?
- QA process?
- Who audits the auditors/coders/billers?

Charge Entry

PMG: "How many patient visits last week?"

Former Client: "You should know that. We won't tell."

Quantity

Impact of sub-optimal charge capture?

- Unreported services
    - UDS impact
    - Data deficit for contract negotiation
- Low provider productivity
- Lost or delayed payment
- Patient dissatisfaction
- Increased denials
- Compliance inquiries

Auditing Charge Entry

Quantity

- Are all appointments that were kept, entered?
- What reconciliation process exists for any paper encounter forms?
- Did any claims fail validation?
- Did any claims reject?
- What reports are run daily or weekly to ensure accuracy?
- Who holds each stakeholder accountable?

Processes and Audits for the Revenue Cycle

Front Desk

Documentation & Coding

Charge Entry
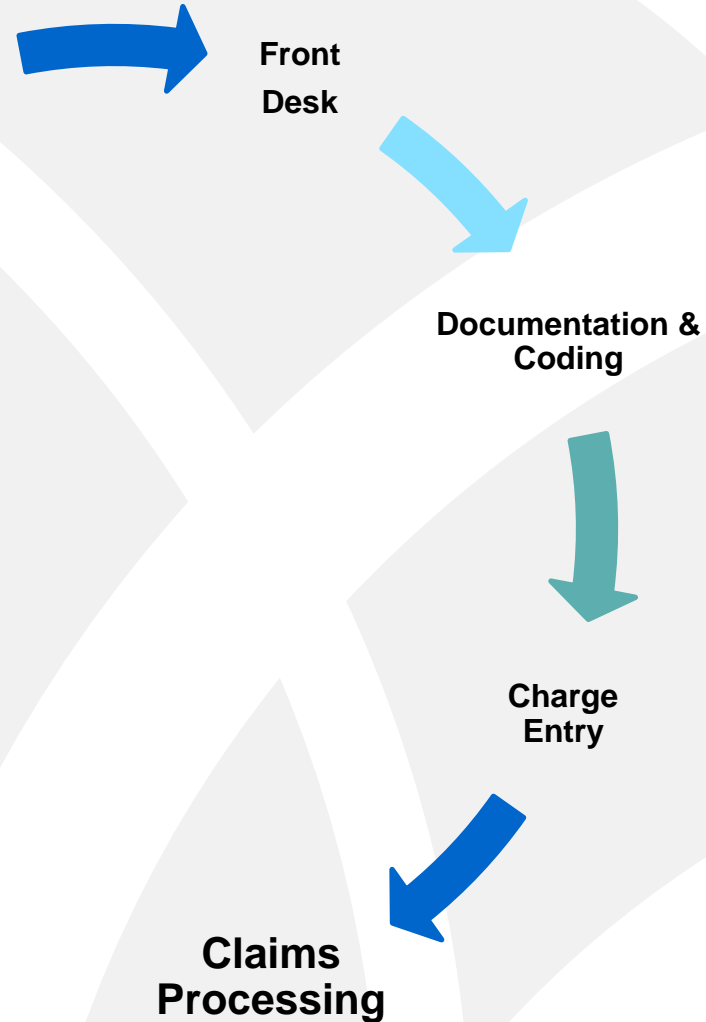
Claims Processing

Auditing Claims Processing

Claims processing review?

- Timeliness

- Quality

- Quantity

Auditing Claims Processing

"The lady on maternity is the only person who knows how to submit Medicaid claims?"

Timeliness

- Frequency of claim generation?
    - Standard practice is daily
- Daily submission = steady cash flow
- Single daily file fails, recovery less difficult
- Denials worked in more timely manner

Auditing Claims Processing

Quality & Quantity

- Clearinghouse = pre-payer vetting

- Clearinghouse utilized?

- Single clearinghouse accept all claim types?

- Rejections handled efficiently?

- Benchmark for efficiency?

- Clean Claim Rate?

  – I.e., Percent of claims passing through clearinghouse without rejection.

Rejections (999): Clean Claim Rate… Clearinghouse Tracking

*Source System – eSolutions /ClaimRemedi

Rejections (999)
Drill down to the detail! (1 of 2)

REJECTIONS RESULTS		
DESCRIPTION	**COUNT**	**BILLED AMT**
Billing Provider NPI invalid or missing	110	$49,118.91
Patient/Subscriber Insurance ID invalid	51	$10,254.56
Provider certification/credentialing issues or NPI/EIN not on file with payer	5	$866.60
Procedure Code invalid	2	$78.00
DOS prior to/after coverage terminated	1	$381.51
Patient/Subscriber not on file with payer	1	$195.00

TOP PAYER REJECTIONS BY REASON

August   September   **Month To Date**

*Source System – eSolutions /ClaimRemedi
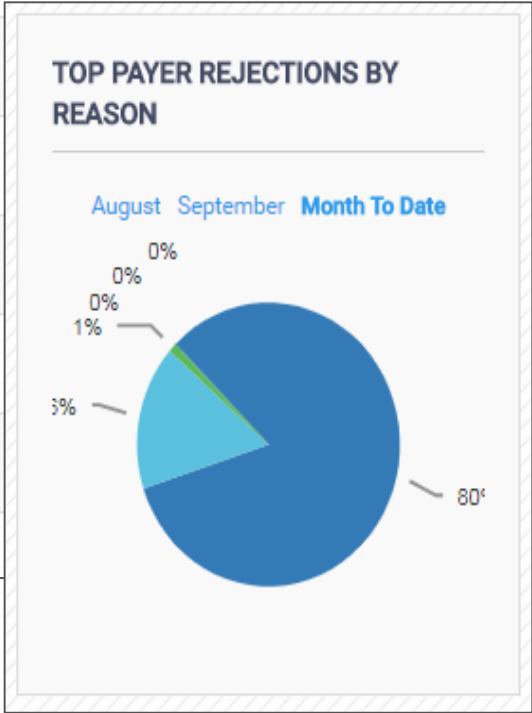
Coming & Going - 837 vs. 835

Outbound Claims - HIPAA x12 ANSI 837

- ANSI 837i: Institutional (UB-04)

- ANSI 837p: Professional (HCFA1500)

- ANSI 837d: Dental = (ADA Claim Form)

Inbound Remittance HIPAA x12 ANSI 835

- Electronic Remittance Advice (ERA)
  - Electronic EOB
- Use HIPAA standard reason and remark codes
  - - **http://www.wpc-edi.com/reference/**
- Obtained through your clearinghouse, directly from the payer

- Contains all payment, denial, & reversal decisions

- Uses HIPAA standard reason codes

A Rejection is <u>Not</u> a Denial ANSI 999 & RTP

Inbound Response File – HIPAA x12 ANSI 999

- Structural edit pass/fail (format is passing)
- Focus on IK5 & AK9
- Either A (accepted) or R (rejected)
- "R" claims typically result of missing required segments
- All claims fail, even good ones
- Once fixed, best to regenerate new claim file for all claims

RTP (Returned to Provider)

- All Medicare claims
- IL Medicaid Black Hole Reports
- Passed 999, no 835 response, No reports sent, Staff must go find data
- Medicare 3:10 = Denied:Paid
- Neither, assume RTP issue

Processes And Audits For The Revenue Cycle

Front Desk

Documentation & Coding

Charge Entry

Claims Processing
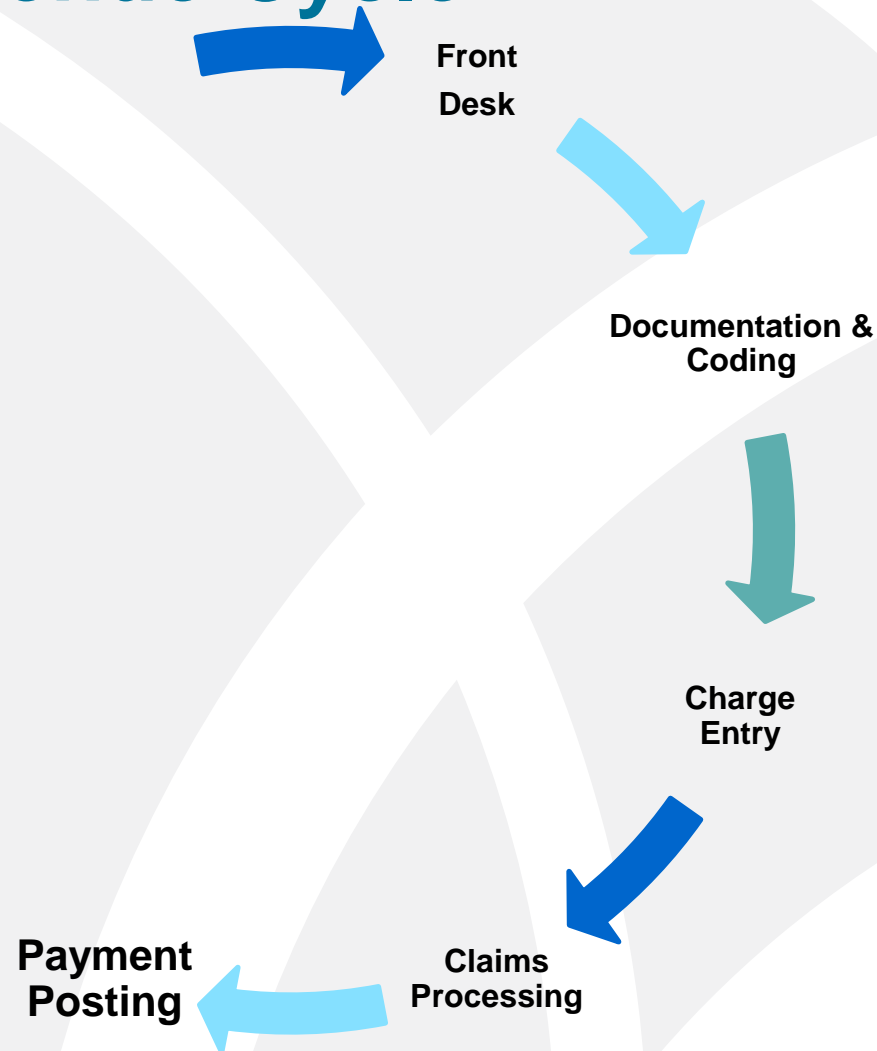
Payment Posting

Payment Posting Terms

- EFT = Electronic Fund Transfer
- ERA = Electronic Remittance Advice
  - Paper conversion to ERA when able
- APP: Automatic Payment Posting
- ERA vs. Paper checks
- EFT & ERA whenever possible

NOTE: Post payments consistent with governmental regulation &/or payer contracts

Payment Posting

"We post all payments the week before the finance committee meets."

Payment Posting

- Tracking & reconciling deposits
- Matching ERA to APP
- Posting & reconciling payments in PM
- Posting full or partial denials in PM

Payment Posting

Sample process:

- Finance notifies billing of EFT or check

- Funds logged as "received" on Deposit Log

- Paper EOB or ERA retrieved

- ERAs & EOBs posted to PM

- Reconciliation PM batch $ to Deposit Log $

Tracking The Money

- Never miss $$$

- Learn & Post Payer Schedules

  - When should you expect the funds?

  - Medicare: 3:10 (denied:paid)

    - 999/RTP reports

  - Medicaid?

- Process for expected funds not received?

- Expected cash daily, weekly, monthly?

  - Is it reasonable?

- Up-line notification if expected ≠ reality

Electronic vs. Manual Posting

Electronic Posting

- Efficient, standardized, & accurate… Takes time to configure
- Electronic (APP), very fast BUT learning mitigated
- Monitor (audit) manual & electronic Not just posting payments
  - Posting Adjustments
  - Making transfers
  - Paid appropriately according to contract?
- Transfers
  - To patients
  - To secondary payers
  - Payer listed in second position really secondary payer?

Processes And Audits
For The Revenue Cycle

Front Desk

Documentation & Coding

Charge Entry

Denial Management

Payment Posting

Claims Processing
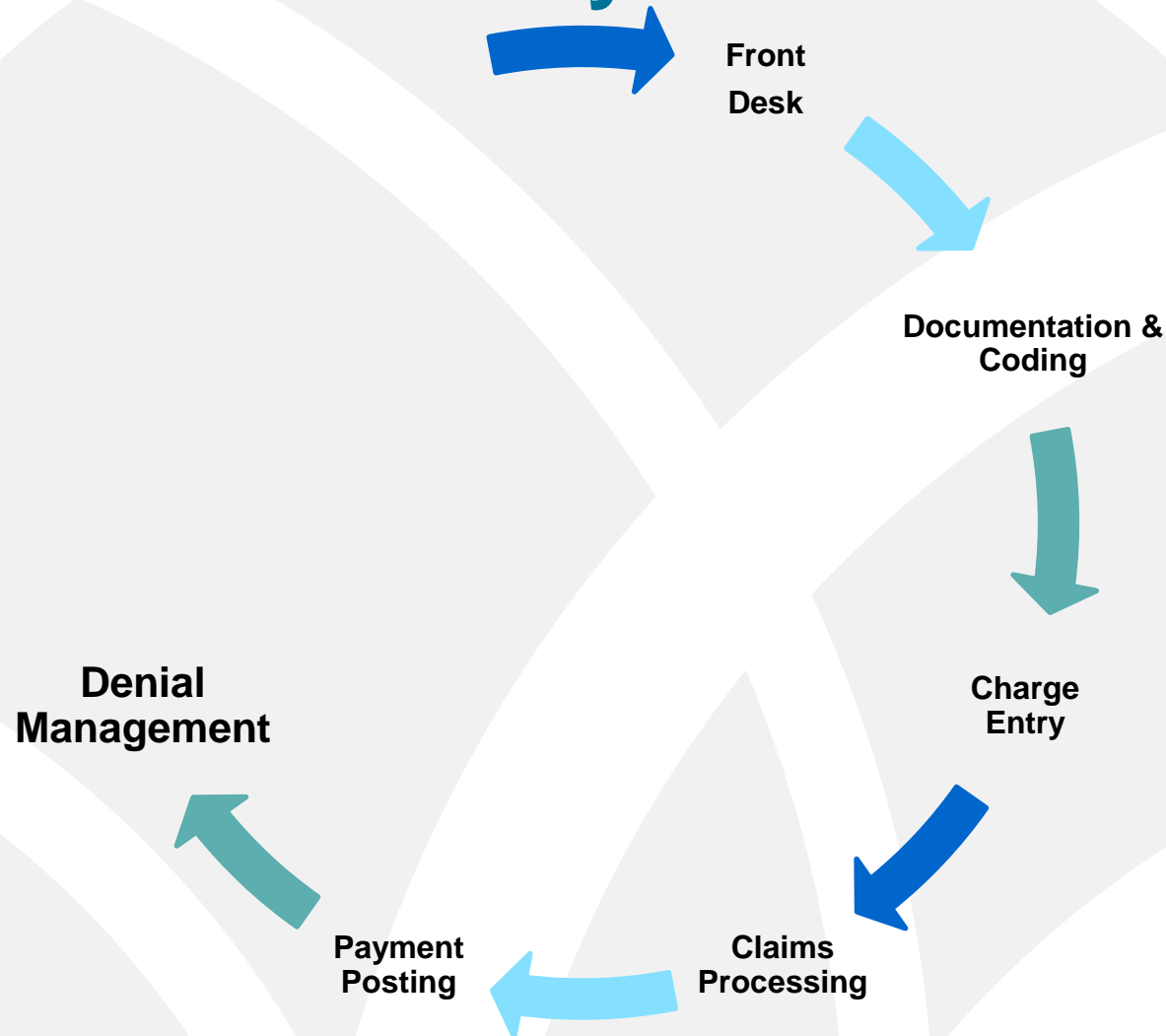
Denials vs. Unpaids

- Denials
  - Quick correction at time of payment posting
  - No research
  - Harder to do when auto-posting payments

- Unpaids (covered in AR Management section)
  - Project Based
  - Elevated complexity
  - Trends/patterns must be found

- Bulk of Unpaids due to "reports" not worked
  - Clearinghouse
  - 999/277CA (Claim Acknowledgement) files
  - 835 files
  - ALL PAPER = A GAP (e.g., secondaries & some commercial)

What is Your Denial Rate?

- Top performing CHCs < 5%

- Difficult to measure across all payers

- Formula:

    # denied claims ÷ # of submitted claims = Denial rate

    E.g., 375 (denied) ÷ 1,000 (total) = 37.5% denial rate

Denial Rate

Denial Statistics (Unique Claims)	#
Paid Claims	129,231
Unpaid/Reversed Claims	32,107
Total Unique Claims	**161,338**
Paid Claims that were Denied (ever)	14,483
Unpaid/Reversed Claims with a denial	23,198
Total Denied Claims	**37,681**
Signifigant Problem	*>8%*
Denial Rate (Denied Claims / Total Claims)	**23%**

#1 Denial Percentage (37,681 ÷ 161,338) = 23%
#2 Quick fixes, no research… (14,483) rectified
#3 Touches (23,198) require manual intervention

Denial Workflow Audit

- Denials tracked?

- How?

- Frequency of work?

- Rule book to fix common denials?

- Rules compliant with regulation & contract?

- Able to mitigate, entirely, certain denials?

Denial Workflow

- Measure Denial Rate
- Categorize
  - Coding
  - Registration & Eligibility
  - Provider Enrollment (credentialing)
  - Claim data insufficient
- Correct & resubmit
  - Denial workflow rule book
- Report
- Document remedial action
- LEARN & IMPROVE!!

Reducing Inbound A/R
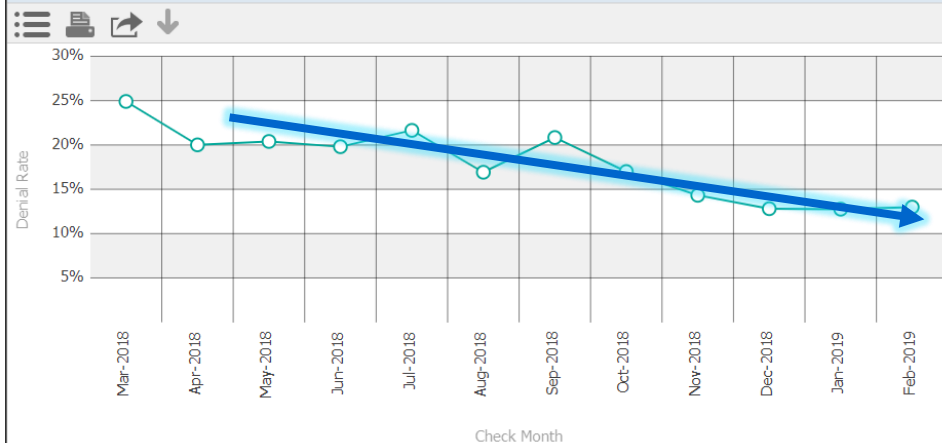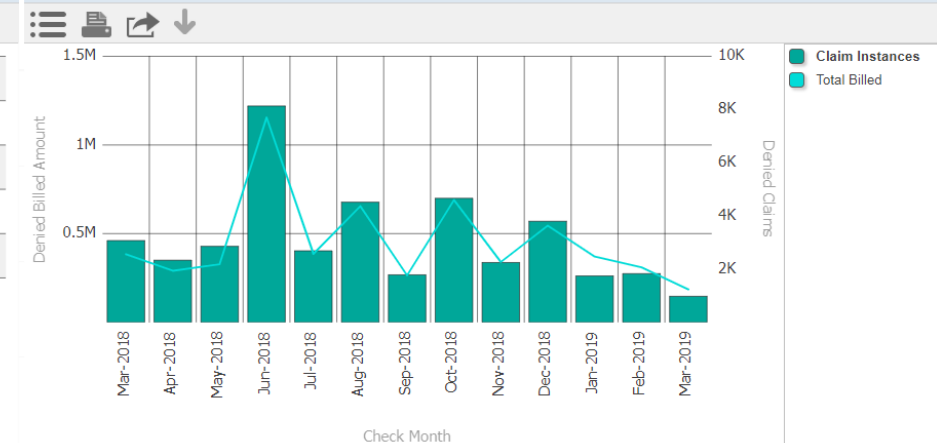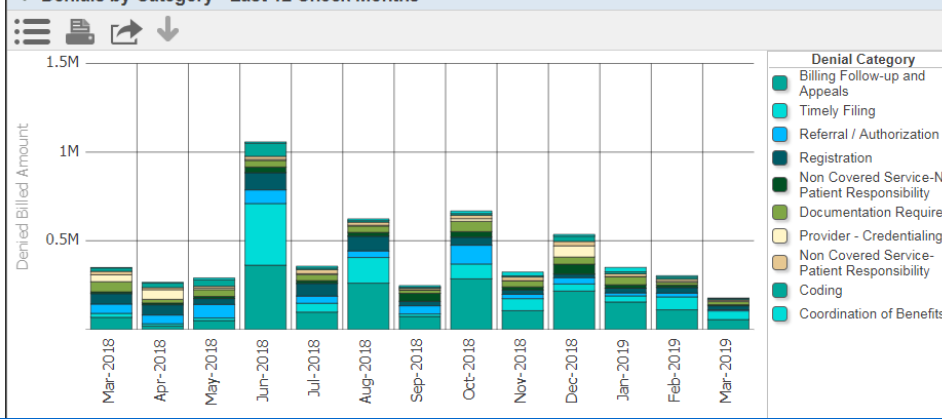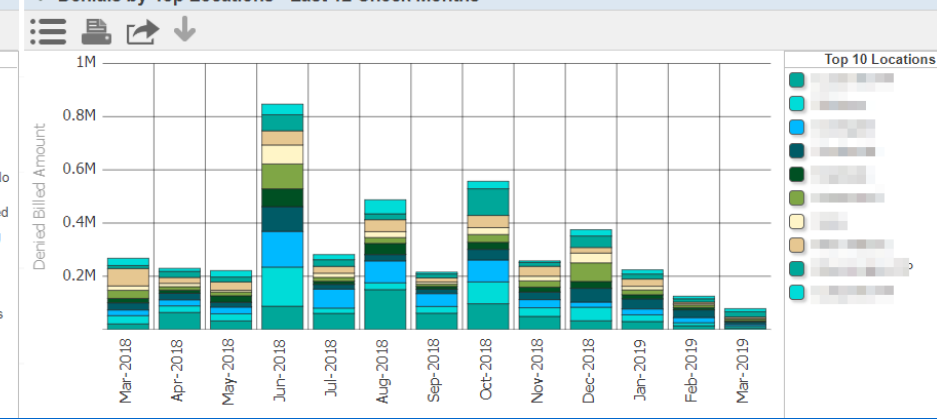
Registration Denial Trending

Processes and Audits
for the Revenue Cycle

Front Desk

Documentation & Coding

Charge Entry

Claims Processing

Payment Posting

Denial Management

AR Management

AR Management Audit

- Remaining claims after unpaid workflows complete
- Measure Days in Accounts Receivable (DAR/DSO)
  - Total AR ÷ Average Daily Charge = DAR/DSO
- AR by payer
- Total AR buckets
  - 0-30 days
  - 31-60 days
  - 61-90 days
  - > 120 days
- Payer adjudication timelines determine success
  - Medicare > 30 days

AR Management Audit

- Categorize by reason of non-payment
  - Similar to the denials?
- Category Examples:
  - Credentialing: Written off?
  - Eligibility: Patient responsibility?
- Correct & resubmit or write off
  - Denial workflow rule book
- Earlier RCM workflows…
  - Not followed?
  - Deficient?
  - Absent?
- Report and correct workflow

AR Management Audit

- Categorize by reason of non-payment
  - Similar to the denials?

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Credentialing Challenges
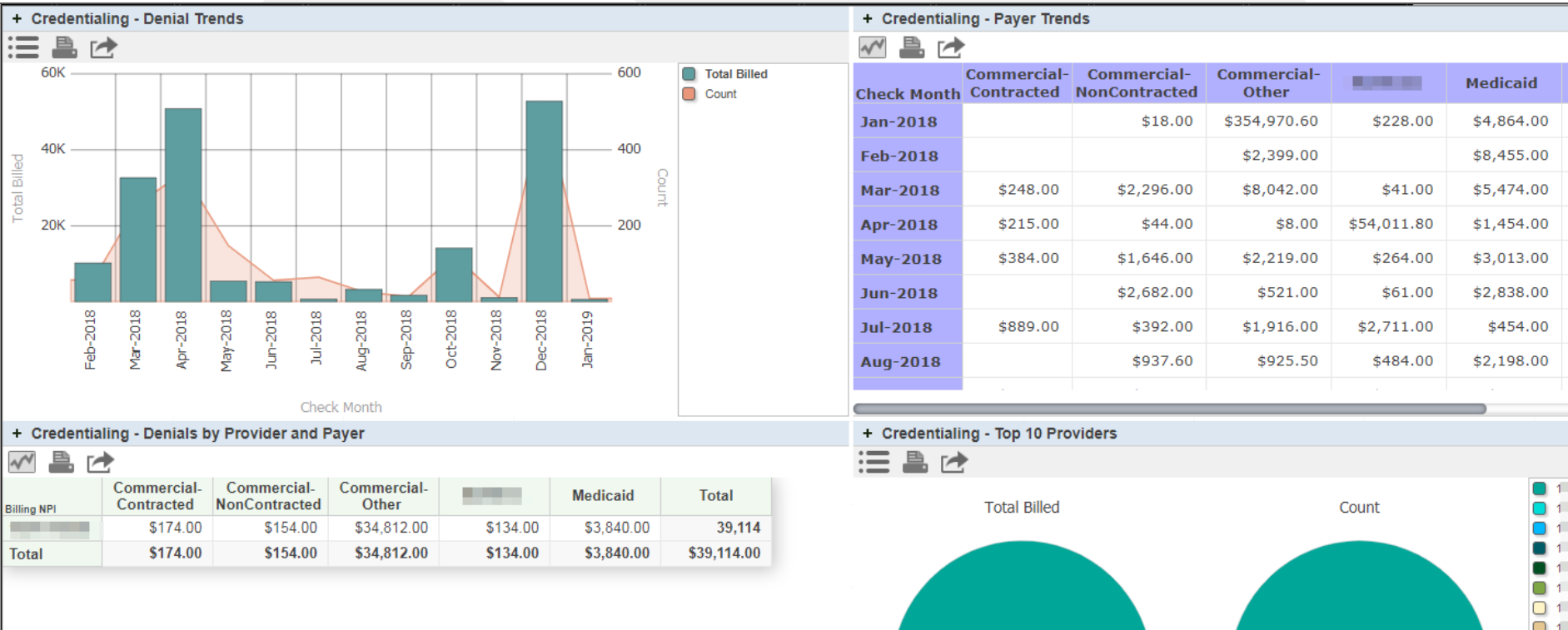
Help Staff Learn to Help Themselves

Volumes of Actionable KPIs

Processes and Audits for the Revenue Cycle

Key Performance Indicators

Front Desk

Documentation & Coding

Charge Entry

Claims Processing

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AR Management
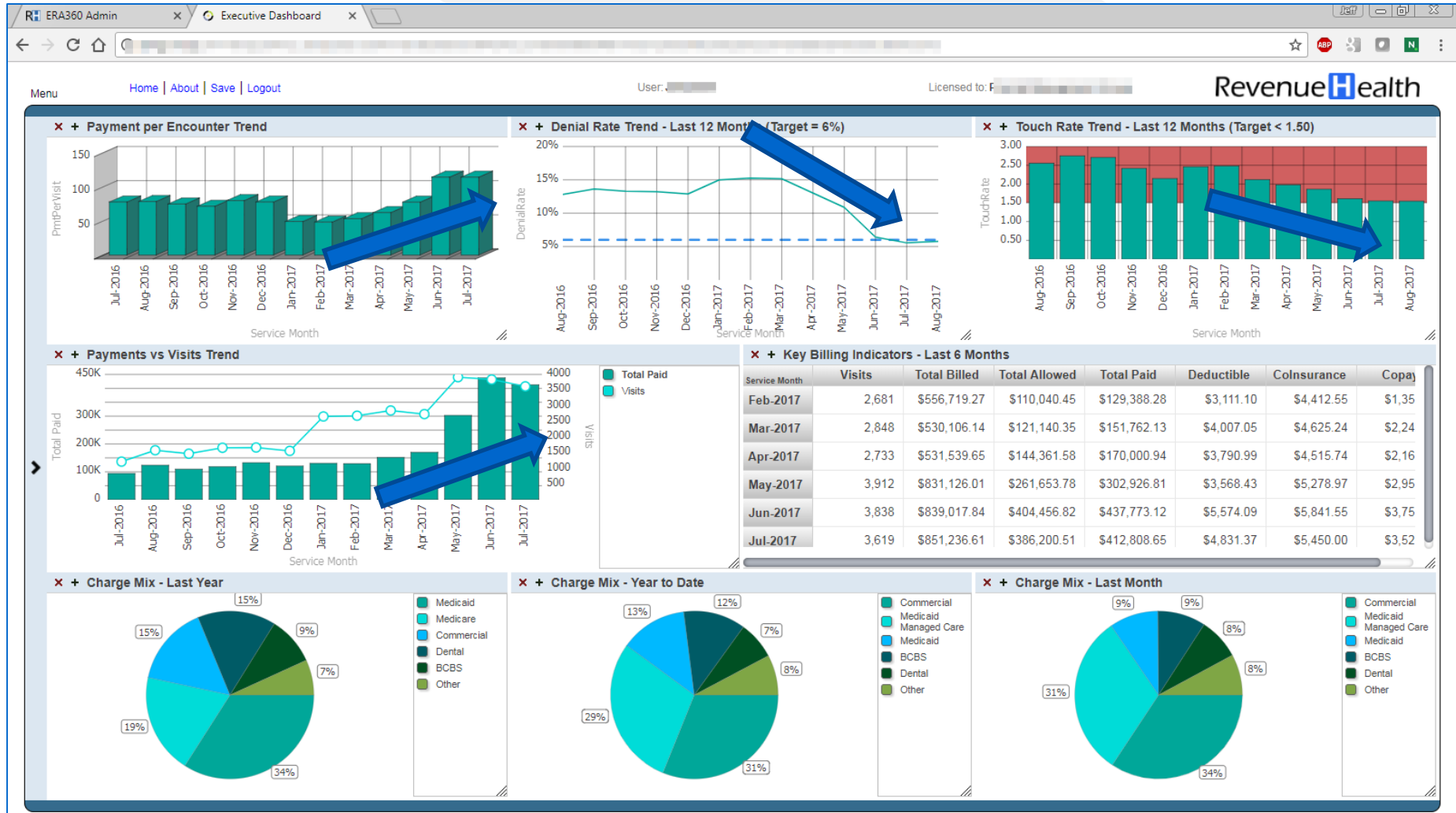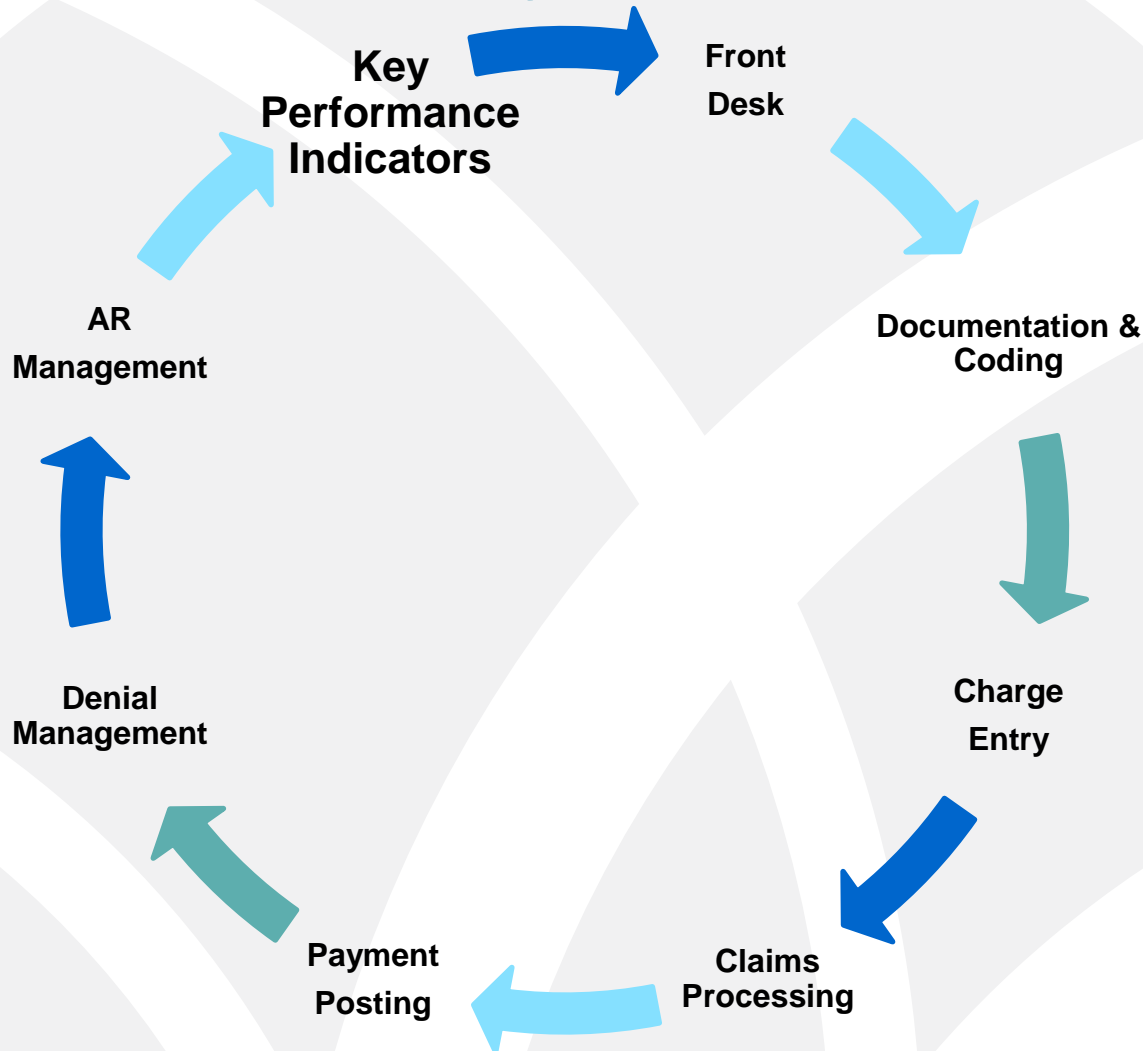
KPI

- Provider coding completion: Same day as DOS
- Charge Entry: < 2 days of DOS
- Claim Transmission: within 2 days of charge
- Payment Posting: < 3 days of EOB/check receipt
- DAR/DSO: Top tier = 30-40 days
- AR >90 Days: < 20%
- Denial Rate: < 10%
- RCM Staffing: 1 FTE per 12-14K 3rd party visits

Summary

- Get your team together

- Select a communication lead

- Observe current practices

- Define processes

- Conduct internal audits

- Train & educate

- Improve, in perpetuity

Questions?